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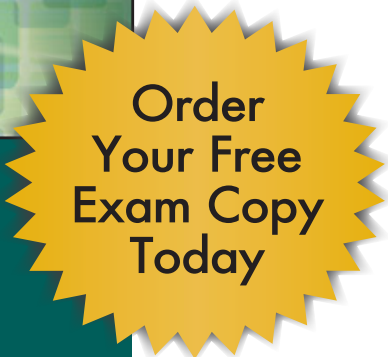
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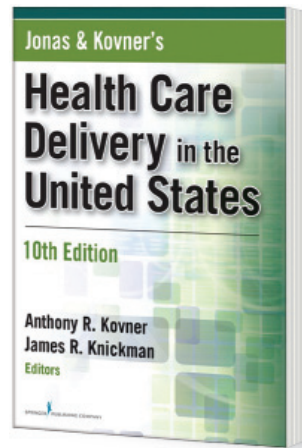
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Jonas & Kovner's Health Care Delivery in the United States

10th Edition

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Thoroughly revised and updated, this 10th edition of a classic textbook for graduate and advanced undergraduate students presents the critical issues and core challenges surrounding our health care system. Leading thinkers, educators, and practitioners provide an in-depth and objective appraisal of why and how we organize health care the way we do; the enormous impact of health-related behaviors on the structure, function, and cost of the health care delivery system; and of other emerging and recurrent issues in health policy, health care management, and public health.

Key Features:

- Includes major provisions of the Patient Protection and Affordable Health Care Act of 2010
- Rigorously objective, with policy analysis clearly separated from discussion of the health care system
- Covers the newest models of care such as Accountable Care Organizations and Integrated Delivery Systems
- Examines new ways of conceptualizing and assessing health care including comparative effectiveness research
- Features contributions by leading scholars and key figures within the U.S. health care system, including: John Billings, JD; Carolyn M. Clancy, MD; C. Tracy Orleans, PhD; Michael S. Sparer, PhD, JD
- Contains new coverage of health reform, developing countries, population health, public health and catastrophic events, and a broadened discussion of the health care work force
- Evaluates the constraints and opportunities leaders face in trying to standardize quality outcomes, contain increases in health care costs, and improve access to health care

This text is divided into five sections, in order to provide some coherence to this broad terrain. **Part I, The Current US Health Care System**, addresses major characteristics and issues, including reform, financing, and comparative health care systems. This section now includes multiple new charts and tables providing concrete health care data. **Part II, Population Health**, focuses on health behavior, including health care models, public health policy and practice, risk factors, facilitating healthy lifestyle practices, and access to care. **Part III, Medical Care Delivery**, addresses integrated health models, delivering high quality health care, cost and value, and comparative effectiveness. **Part IV, Support for Medical Care Delivery**, concerns governance and management issues, including accountability, the health workforce, and information technology. **Part V, The Future of Health Care Delivery in the United States**, includes a new five-year trend forecast.

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KEY TERMS

LEARNING OBJECTIVES

TOPICAL OUTLINES

INFORMATIVE CASE STUDIES

DISCUSSION QUESTIONS

COMPARATIVE EFFECTIVENESS
Amir Satvat and Jessica Knight

KEY WORDS
comparative effectiveness; variations in care; comparative effectiveness research (CER); national institute for health and clinical excellence—U.K. (NICE); national health service—U.K. (NHS); quality adjusted life years (QALY); haute autorité de santé—France (HAS); institut für qualität und wirtschaftlichkeit im gesundheitswesen—Germany (IQWiG); pharmaceutical benefits advisory committee—Australia (PBAC); formulary; agency for healthcare research and quality—U.S. (AHRQ); rationing.

LEARNING OBJECTIVES

- Learn the purpose, function, and mechanisms of comparative effectiveness systems
- Understand how comparative effectiveness functions in other countries today
- Consider a blueprint for comparative effectiveness based on international experiences
- Understand the key issues in the debate about implementing comparative effectiveness in the U.S. health care system
- Construct an ideal "amalgam" system for comparative effectiveness

TOPICAL OUTLINE

- What comparative effectiveness is all about
- Comparative effectiveness program models
- Benefits of comparative effectiveness systems
- Public and private comparative effectiveness systems
- The U.S. debate on comparative effectiveness systems
- Comparative effectiveness systems: guidelines for design

What Comparative Effectiveness is All About

Over recent decades, as health systems have grown in complexity and scope and as health technology has developed at a staggering rate, developed country health systems have faced two principal challenges: maintaining and standardizing quality and controlling costs. A well-functioning health system must first ensure that effective new interventions

CASE STUDY

Certificate of need (CON) legislation was designed to control costs by limiting the approval of new construction and new health care services based on demand for those services. By limiting supply, the CON would allow efficient development of the health care infrastructure. The first CON legislation was enacted in New York State in 1964. Other states enacted various forms of CON legislation and, in 1974, the Nixon administration supported federal legislation calling for all 50 states to enact CON laws. This mandate stood for 13 years until it was repealed in 1987. Today 36 states retain their CON laws. Without CON legislation, the health care environment becomes a free market with open competition and decision making about expanding services that are not directly related to the demand for them. For example, Pennsylvania's CON legislation sunset in 1996. With the market freed from CON supply and demand controls, the state saw significant changes in health care services. A case in point is open heart surgery—a highly profitable service, which often supports many of a hospital's money-losing services that are, nonetheless, part of its mission. With the lifting of CON controls, from 1996–1997 to 2007–2008, Pennsylvania experienced a 25% increase in the number of hospitals providing open heart surgery, even though the number of procedures across the state declined 37% during that period. The result was that the average annual volume per hospital declined 49%, from 653 to 300. At the same time, as well documented, that facilities performing a higher volume of complex surgery have better patient outcomes and that it can be dangerous to have such services in facilities that do too few of them. This change resulted not only in less efficient use of clinical facilities, cardiothoracic surgeons, highly skilled surgical teams, but also resulted in a change in the landscape of health care. The Philadelphia five-county region experienced similar changes, which contributed to the closure of three urban teaching hospitals: Medical College of Pennsylvania, Graduate Hospital, and Episcopal Hospital.

CASE STUDY DISCUSSION

1. Why would so many open heart programs be launched, in the face of a declining market?
2. Were the new programs justified?
3. What would you do to rationalize the number of programs in an open and free market? If you were the governor of Pennsylvania, what issues would you consider in returning to a CON-based health care environment?

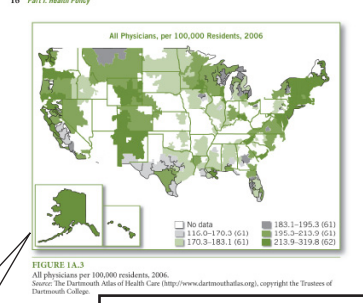
REFERENCES

American Hospital Association. (2009). Underpayment by Medicare and Medicaid. Fact Sheet. Retrieved September 13, 2010, from <http://www.aha.org/aha/content/2009/09/13/underpay.pdf>

RIGOROUSLY OBJECTIVE, WITH POLICY ANALYSIS CLEARLY SEPARATED

VIVIDLY ILLUSTRATED WITH MAPS AND CHARTS THROUGHOUT THE TEXT

KEY CONCEPTS HIGHLIGHTED THROUGHOUT



The Department of Health and Human Services

The federal government has been involved in health affairs since the late 1700s (Figure 1A.1). DHHS is the largest federal department after the Department of Defense, with a requested 2011 budget of more than \$900 million. The accompanying timeline uses agencies' current names, many of which have changed numerous times as their roles evolved. The years tell when the agency or its principal predecessor began; a second year indicates a major reorganization.

The \$20 billion a year National Institutes of Health began as a one-room disease research laboratory on Staten Island.

Case studies now included in every chapter!

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NEW 5. Population Health

6. Public Health: Policy, Practice, and Perceptions
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Part III: Health Care Delivery

NEW 9. Organization of Medical Care

NEW 10. Integrative Models and Performance

11. High Quality Health Care
12. Health Care Costs and Value

NEW 13. Comparative Effectiveness

Part IV: Support for Health Care Delivery

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